

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G252 11-30-59 et

CERTIFICATE OF DEATH

12647

12668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Rock Hall</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Clothier</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 11, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>07</b> Days <b>07</b> Hours <b>00</b> Min. <b>00</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Clothier (First name unknown)</b>		14. MOTHER'S MAIDEN NAME <b>Emma Dephen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-16-9746</b>		17. INFORMANT <b>Mrs. Ruth Clothier--Rock Hall, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tubercular Edema</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Generalized Cerebral Crystallization</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. 11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Rock Hall</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 6</b> , 19 <b>59</b> , to <b>Nov 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 5</b> , 19 <b>59</b> , and that death occurred at <b>10 30</b> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norbert C Nitsch</b>				M.D. <b>Rock Hall</b>			
PHYSICIAN'S NAME (Type) <b>NORBERT C NITSCH</b>				<b>ROCK-HALL-MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 21</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>			

MASSACHUSETTS DEPARTMENT OF REVENUE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12648

12669

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES LEE CRANFILL JR</u>		4. DATE OF DEATH <u>NOV 3 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 14, 1944</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES LEE CRANFILL</u>		14. MOTHER'S MAIDEN NAME <u>MEDRA MIDGETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS C. L. CRANFILL</u>		Address <u>WORTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN INJURY</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HIT BY CAR</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 3 1959</u> Hour <u>7</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>	20f. (City or town) <u>WORTON</u> (County) <u>KENT</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Arthur T. Keefe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A T KEEFE, JR. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-6-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u>		22d. LOCATION (City, town, or county) <u>CHESTERTOWN, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kneass</u> DATE <u>NOV 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or. Page 4 to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

12670

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	c. LENGTH OF STAY IN 1b <i>life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Skinner's Rock</i>		d. STREET ADDRESS <i>Skinner's Rock</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Goldy</i> Last <i>Elburn</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 1911</i>
9. AGE (In years last birthday) <i>48</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Estate</i>	11. BIRTHPLACE (State or foreign country) <i>Rock Hall, Kent Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Elburn</i>	
14. MOTHER'S MAIDEN NAME <i>Alice Brady</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>215-20-0019</i>		17. INFORMANT <i>Mrs. Clara Elburn</i> Address <i>Rock Hall P.O. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks?</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 10, 1959</i> , to <i>November 15, 1959</i> , that I last saw the deceased alive on <i>November 14, 1959</i> , and that death occurred at <i>3:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Chesertown, Md.</i> DATE SIGNED <i>11-15-59</i>			
ACTUAL SIGNATURE <i>A.C. Dick</i> M.D.			
PHYSICIAN'S NAME (Type) <i>A.C. Dick</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 17, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel Am. T.</i>	22d. LOCATION (City, town, or county) (State) <i>Rock Hall Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Williams</i>		ADDRESS <i>Chesertown, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 18 1959</i>		24b. REGISTRAR'S SIGNATURE <i>William J. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13870

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		65		JAN 15 1880		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1940		10:15 AM		10:15		10:15		10:15	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1940		JAN 20 1940		JAN 20 1940		JAN 20 1940		JAN 20 1940	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR.

12661

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betherton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Celena</u> Last <u>Eley</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Berne, Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Rawley</u>		14. MOTHER'S MAIDEN NAME <u>Susan Abnet</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, generalized</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma (original site unknown)</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9, 1959</u> , to <u>November 28, 1959</u> , that I last saw the deceased alive on <u>November 28, 1959</u> , and that death occurred at <u>6:00 p</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>				DATE SIGNED <u>11-28-59</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u>				PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Ameyra Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Hall</u> ADDRESS <u>1111 N. Main St.</u>				24. REC'D BY REGISTRAR <u>Christ S. Harris</u> DATE <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12671

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton RFD (Coleman's)</b>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home</b>		d. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>J.</b> Last <b>Frisby</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> , Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR: Months <b>90</b> Days <b>90</b> Hours <b>90</b> Min. <b>90</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Brown</b>		14. MOTHER'S MAIDEN NAME <b>Jane Kennard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Marie Gibbs daughter</b> Address <b>Worton R.F.D. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary oedema</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right sided heart failure</b> DUE TO (c) <b>Cardiac hypertrophy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardio renal disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 1</b> 19 <b>59</b> to <b>Nov. 26</b> 19 <b>59</b> that I last saw the deceased alive on <b>Nov. 26</b> 19 <b>59</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b> M.D.		ADDRESS (Street, city or town, state) <b>Worton, Md RFD</b> DATE SIGNED <b>11/27/59</b>	
PHYSICIAN'S NAME (Type) <b>Florence Deringer Joyce</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 6, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Coleman's Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Worton, Md/ R. F.D;</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b> ADDRESS <b>Ch. to town rd</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

For use in the State of Massachusetts

Revised 1934

For use in the State of Massachusetts

Revised 1934

For use in the State of Massachusetts

Revised 1934

For use in the State of Massachusetts

Revised 1934

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Revised 1934

For use in the State of Massachusetts

Revised 1934

12662  
CERTIFICATE OF DEATH

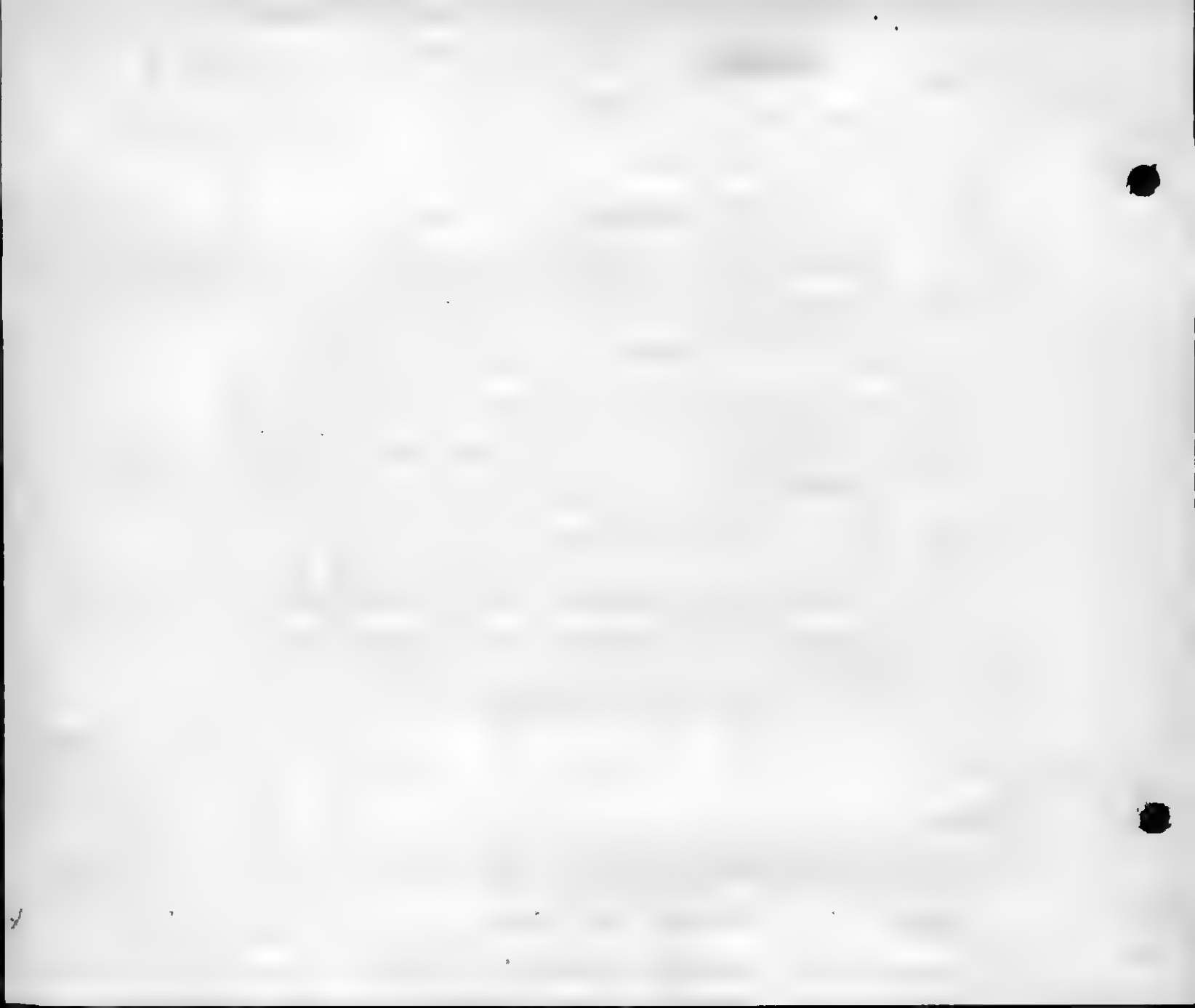
Reg. Dist. No.

12652

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>KENT &amp; QA HOSPITAL</b>		d. STREET ADDRESS <b>430 CALVERT ST</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Henry Johnson</b>		4. DATE OF DEATH Month Day Year <b>Nov 18 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/1912</b>
9. AGE (In years last birthday) yrs <b>47</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>odd jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JAMES JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>TEMPLE GRAVES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES 1 UNK</b>		16. SOCIAL SECURITY NO. <b>220-01-8430</b>	
17. INFORMANT <b>HOSPITAL RECORDS.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OPERATIVE SHOCK</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIOVASCULAR COLLAPSE</b> DUE TO (c) <b>Under Anesthesia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PENETRATING DUODENAL ULCER</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 6, 1959</b> to <b>Nov 18, 1959</b> , that I last saw the deceased alive on <b>Nov 18, 1959</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. T. KEEFE, MD</b>		M.D. <b>CHESTERTOWN, Md</b> DATE SIGNED <b>11-19-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. W. W.</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE NOV 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

TO BE RELIED UPON BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

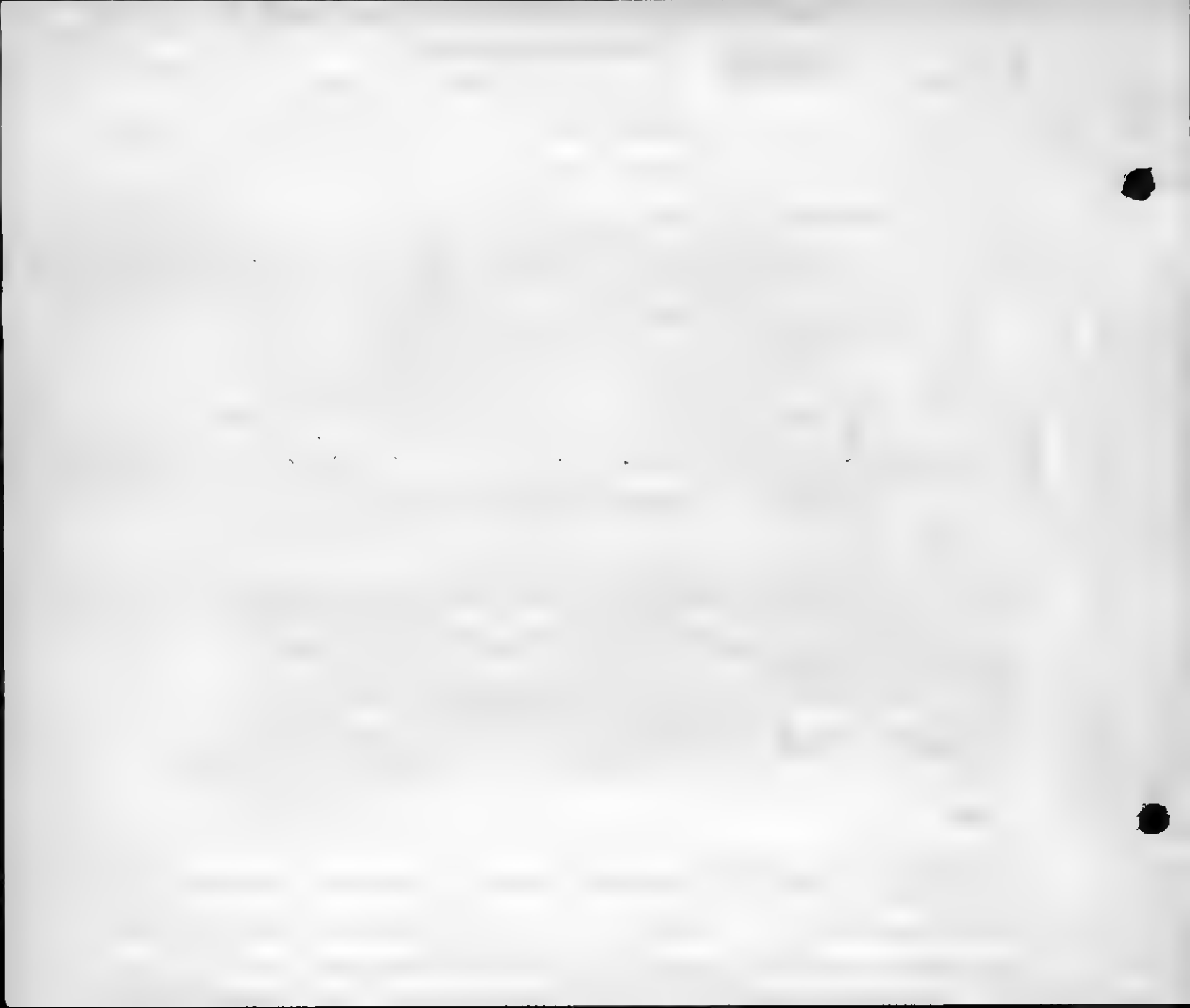
## CERTIFICATE OF DEATH

Reg. Dist. No.

12653

12672

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside</u>				1 d. STREET ADDRESS <u>Seaside</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John Morgan Kendall</u> First Middle Last				4. DATE OF DEATH <u>Nov. 28</u> Month Day Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1905</u>	9. AGE (In years last birthday) <u>53</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Foods</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Columbus Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Lena Scorne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>154-09-9647</u>		17. INFORMANT <u>Mrs. Joseph Hynson - Rock Hall, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart; angina pectoris</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>L</u> DUE TO (c) <u>L</u>							INTERVAL BETWEEN ONSET AND DEATH <u>L</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient dead on my arrival.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>L</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.			20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>L</u>		20f. (City or town) (County) (State) <u>L</u>
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>59</u> , to <u>11/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Kester</u>				ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED <u>md</u>			
PHYSICIAN'S NAME (Type) <u>E. Kester</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Ans.</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams - Chestnut Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. P. Kester</u>	



CERTIFICATE OF DEATH

12654

Reg. Dist. No.

12673

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>MAY</b> Last <b>LAYTON</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 30 - 1911</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES DOWLING</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET CANAMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-12-4974</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>581.1</b> DUE TO <b>Cardio Vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Crisis of End</b> (c) <b>Alcoholic</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1 -</b> , 19 <b>59</b> , to <b>Nov 10 -</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 9 -</b> , 19 <b>59</b> , and that death occurred at <b>12:45</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Marbert C. Tutch</b> M.D.		ADDRESS (Street, city or town, state) <b>Rock Hall Md</b>	
PHYSICIAN'S NAME (Type) <b>Marbert C. Tutch</b>		DATE SIGNED <b>Nov 10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Nov. 12</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WESLEY CHAPEL</b>	22d. LOCATION (City, town, or county) (State) <b>ROCK HALL MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgard L. Lane</b> ADDRESS <b>Church Hill Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 17 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



## 12663 CERTIFICATE OF DEATH

Reg. Dist. No.

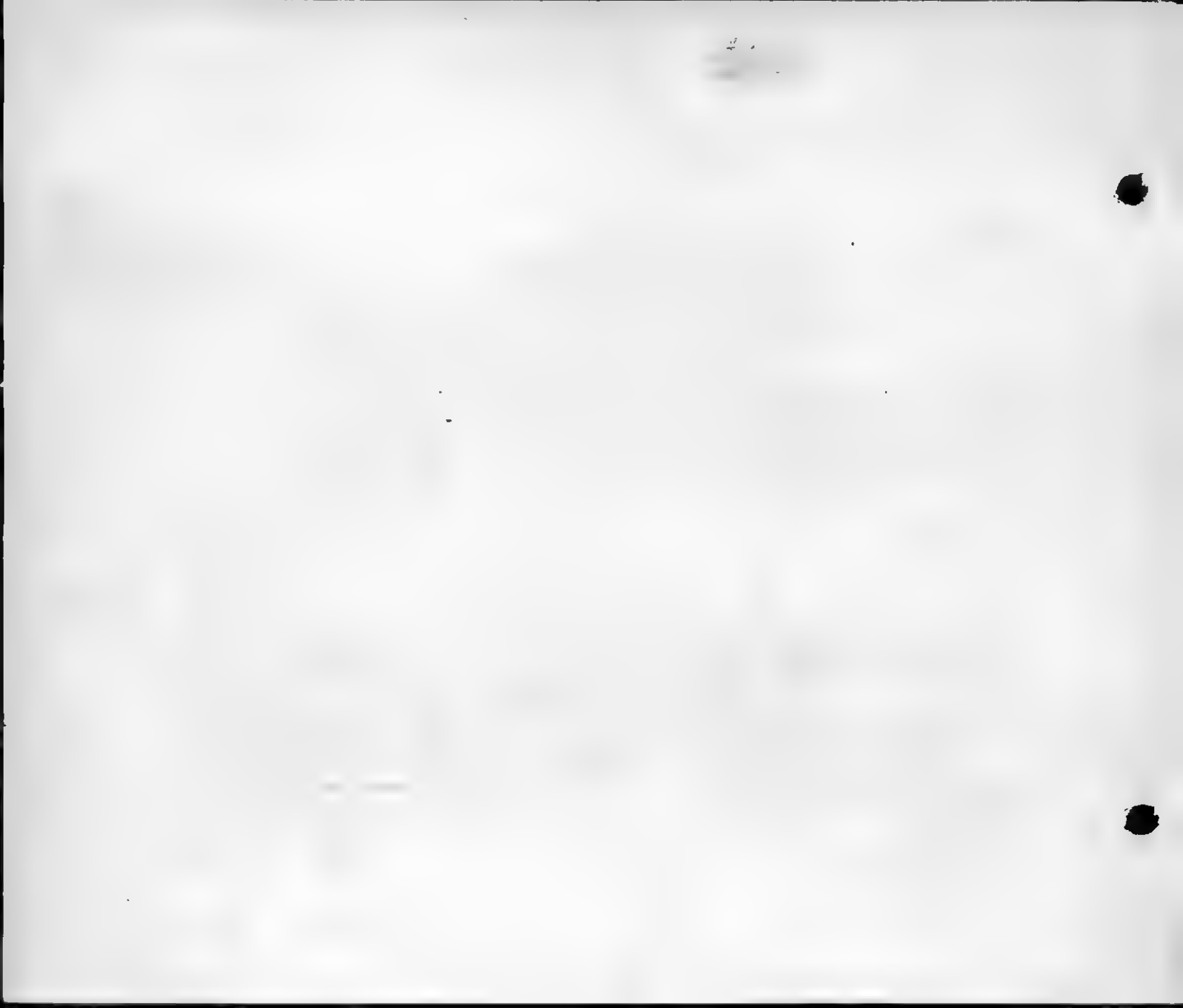
12655

1. PLACE OF DEATH o. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Chestertown</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>104 Water St.</i>				d. STREET ADDRESS <i>104 Water St.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Helin Cooper Metcalfe</i>				4. DATE OF DEATH <i>Nov. 28 1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 12, 1891</i>	
				9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>George S. Cooper</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Stier</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Joseph Brown Metcalfe - Chestertown Md.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Chronic bronchitis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>45 minutes</i> <i>25 years</i> <i>25 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 1953</i> to <i>November 28, 1959</i> , that I last saw the deceased alive on <i>Nov. 27</i> , 1959, and that death occurred at <i>9:03 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.C. Dick</i> M.D.				ADDRESS (Street, city or town, state) <i>Chestertown, Md.</i>			
PHYSICIAN'S NAME (Type) <i>A.C. Dick</i>				DATE SIGNED <i>11-30-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 30/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chestertown Cemetery</i>		22d. LOCATION (City/town, or county) (State) <i>Chestertown Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Wilkman - Chestertown Md.</i>				ADDRESS <i>Chestertown Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	
				24a. REC'D BY REGISTRAR <i>DEC 3 '59</i>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12664

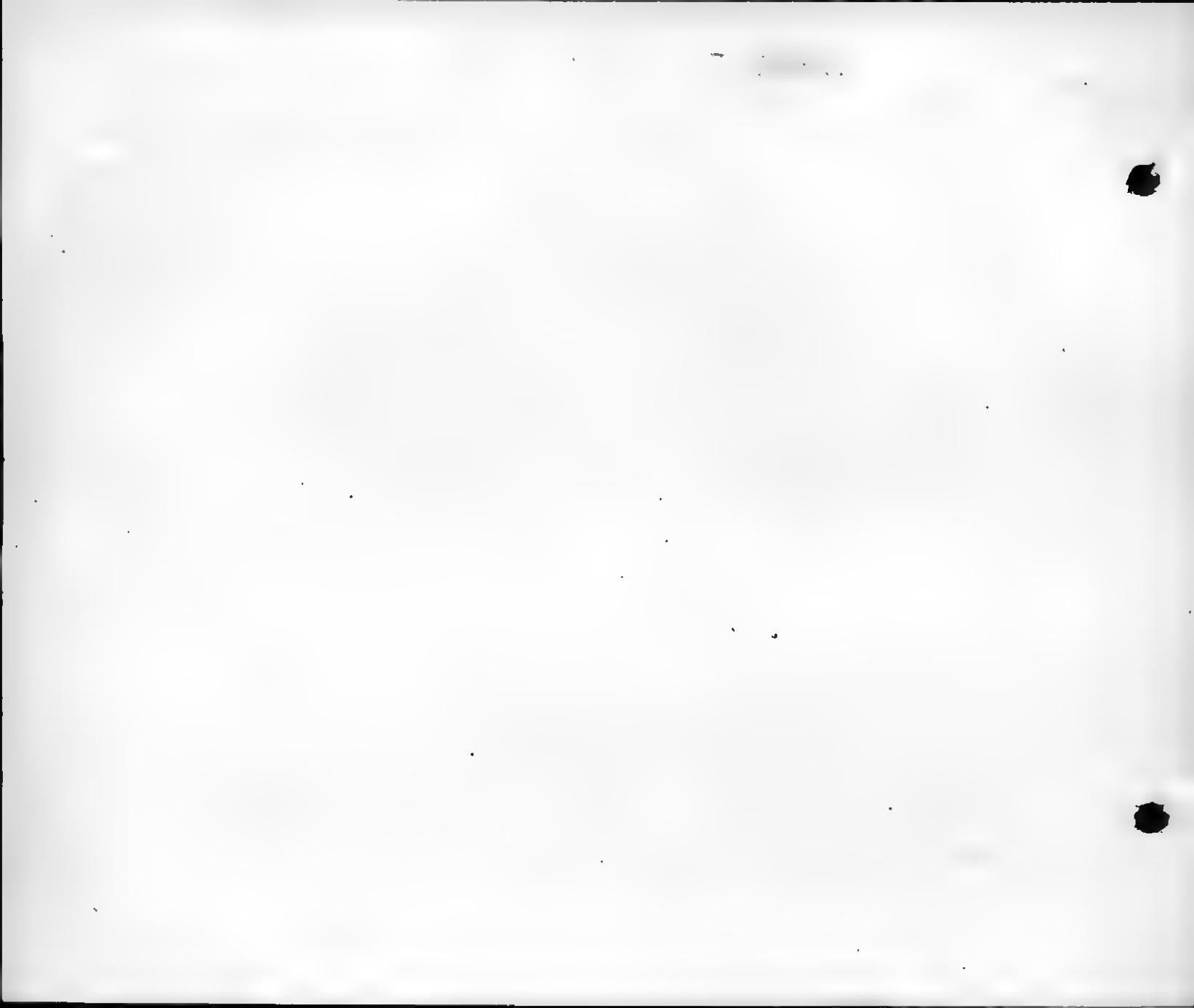
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Kent</u> <u>Chestertown</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown R D. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent - Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James A. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emm. Bruff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Daughter - Mrs. Em Bailey</u>		Address <u>  </u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>1 week</u> <u>2 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4) Arteriosclerosis genl</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 5, 1959</u> to <u>Nov. 8, 1959</u> , that I last saw the deceased alive on <u>Nov. 7, 1959</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John R. Smith Jr.</u> MD		ADDRESS (Street, city or town, state) <u>117 Waters St., Centerville Md</u>	
PHYSICIAN'S NAME (Type) <u>John R. Smith Jr.</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Fairlee Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Sam C. Luck Hill Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '59</u>	
ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



12665

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sudersville 11</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kent &amp; Queen Ann's Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Baby Boy Unruh</i>		4. DATE OF DEATH Month Day Year <i>November 11 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/59</i>
9. AGE (In years lost birthday) yrs. <i>4</i>		IF UNDER 1 YEAR Months Days Hrs Min <i>4</i>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
13. FATHER'S NAME <i>Samuel Unruh</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Fisher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
INFORMANT Address <i>Hospital Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anencephaly</i> DUE TO <i>150X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year. Hour a. m. p. m. <i>11-11-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-11-59</i> to <i>11-11-59</i> , that I last saw the deceased alive on <i>11-11-59</i> , 19 <i>59</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>O. B. Gulbrandson</i> M.D.		ADDRESS (Street, city or town, state) <i>CHESTERTOWN, MD.</i> DATE SIGNED <i>11-12-59</i>	
PHYSICIAN'S NAME (Type) <i>O. B. GULBRANDSEN, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chester Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Chestertown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i> ADDRESS <i>Chestertown, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Willis &amp; Krand</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

12666

CERTIFICATE OF DEATH

12658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN life <b>37</b> <b>Chestertown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Water St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Geraldine W. Whitworth</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> , Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife &amp; Reg. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. B. Wilmer</b>		14. MOTHER'S MAIDEN NAME <b>Ada Leonora Jessop</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarct</b> <b>420.1</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>1 year</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1943</b> to <b>November 30, 1959</b> that I last saw the deceased alive on <b>November 13, 1959</b> and that death occurred at <b>4:05 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Dick</b>		DATE SIGNED <b>12/1/59</b>	
PHYSICIAN'S NAME (Type) <b>A. C. Dick</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 3 '59</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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15208

CONTINUED FROM PAGE 14

(1) (2) (3)

WILLIAM J. BROWN

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/84 BY SP4 JAC/STW

## CERTIFICATE OF DEATH

Reg. Dist. No.

12659

12667

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>46 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Jewell</b> Last <b>Yingling</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Jewell</b>		14. MOTHER'S MAIDEN NAME <b>Sally Jervis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sallie J. Parsons</b>		Address <b>Worton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, (generalized metastasis)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Breast carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-8-</b> <b>19 59</b> to <b>11-24-</b> <b>19 59</b> , that I last saw the deceased alive on <b>11-23-</b> <b>19 59</b> , and that death occurred at <b>6:20 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 N. Queen Street</b> DATE SIGNED <b>11-24-59</b>			
ACTUAL SIGNATURE <b>Harry Paul Ross</b>		M.D. <b>203 N. Queen Street</b> <b>11-24-59</b>	
PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS, M.D.</b>		<b>Chestertown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chestertown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of", "in" are visible.]*